DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 14 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 8548

Registration District No. 896 Primary Registration District No. 6200 Registrar's No. 8

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1. PLACE OF DEATH:
(a) County Webster
(b) City or town rural - High Prarie township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: x
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution x
In this community 25 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Webster
(c) City or town rural - High Prarie township
(If outside city or town limits, write "RURAL")
(d) Street No. x
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 40 years.

3. (a) PRINT FULL NAME Dora Jaich
3. (b) If veteran, name war x
3. (c) Social Security No. x
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Alois
6. (c) Age of husband or wife if alive x years
7. Birth date of deceased December 2, 1860 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	79	2	29	hr. min.

9. Birthplace Germany (City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business Home
FATHER 12. Name Unknown
13. Birthplace Unknown (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)
16. (a) Informant's own signature Rufus Alexander
(b) Address Marshfield, Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 3 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Black Oak
18. (a) Signature of funeral director Rex Gainey
(b) Address Marshfield, Mo.
19. (a) 2-27-40 (Date received local registrar) (b) Elizabeth Highfue (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 2 year 1940 hour 11 minute p. M.
21. I hereby certify that I attended the deceased from Feb. 10 - Feb-10, 1940, to Mar 2, 1940
that I last saw her alive on Feb - 2 - 40, 19
and that death occurred on the date and hour stated above.

Immediate cause of death Double Lobar Pneumonia fever — Duration
Due to Fall and Fracture of left hip &
Due to left arm
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury
23. Signature W. F. Gehlert (M. D. or other)
Address Niangua Date signed 3/4/40

(Licensed Embalmer's Statement on Reverse Side)

Rev. 5-17-39 I X19511

RECEIVED
District Health Officer No. 6,
District File Number 3240-839
Date Filed MAR 13 1940

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

S. No. 2B
M—2-21-40
I X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 8548

Registration District No. 896 | Primary Registration District No. 6200 | Registrar's No.

1. PLACE OF DEATH:
(a) County Webster
(b) ~~City or town~~ High Prairie
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Dora Schlicht
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 79 | Months 2 | Days 29 | If less than one day, hrs. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
FATHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 2
year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Double Lobar Pneumonia	
Due to Fall and fracture of left hip and left arm	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings of operations	
Findings of autopsy	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? Means of injury

23. Signature W. F. Schlicht (M. D. or other)
Address Marquand Mo Date signed

SUPPLEMENTARY